Department of Veterans Affairs **VHA DIRECTIVE 2000-035**
Veterans Health Administration
Washington, DC, 20420 **October 5, 2000**

TELEPHONE CARE AND SERVICE

1. PURPOSE: This Veterans Health Administration (VHA) directive establishes policy and guidance related to 24-hour-a-day, seven-day-a-week (24x7) telephone access to health care advice and information.

2. BACKGROUND

a. VHA has implemented a new initiative to improve service and access for veterans. One of the published goals of this initiative is that patients will have access 24x7 via telephone to health care and clinical consultation. ***NOTE:*** *Access to telephone advice is a commonly provided service for most health plans today.*

b. The purpose of providing 24x7 telephone access to clinical staff is to provide veterans with timely access to information and to provide veterans with a consistent and easily accessible source of information and education when they need or desire it. Call centers may be utilized as an interface with emergency care. The intent of telephone care is to facilitate the veteran's access to timely information and health care services and is not intended to set barriers for veterans who wish to receive care or services.

c. Currently, VHA has a number of Telephone Care programs across the country. These programs vary in design, purpose and hours of operation and the intent of this directive is to set forth requirements for standardization and measures in key areas.

d. The goals of telephone access to care and services are to:

(1) Provide safe, timely, and consistent clinical advice.

(2) Provide 24x7 access to health care services through coordinated telephone coverage.

(3) Ensure that telephone access is fully integrated with and is a component of primary and ambulatory care, including community-based outpatient clinics, specialty and sub-specialty clinics, and other clinical services.

(4) Optimize utilization of services to improve overall access and to reduce waits and delays.

(5) Enhance veterans' ability to self-manage, problem-solve and cope via telephone advice and counseling.

THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2005

e. **Definitions**

(1) **Telephone Care.** The provision of health care advice, information, and facilitation of access to care through telephone systems, as necessary.

(2) **Call Center and/or Clinical Call Centers**

(a) Network or Regional Call Center. A dedicated centralized program, with a devoted qualified staff supported by clinical decision support tools and operational policies and procedures, under the supervision of a physician medical or clinical Director, that serves one or more Networks and whose primary goals are to improve overall health and maximize the use of health care resources. It is designed to assist and educate veterans who access triage or health information services in making decisions on the actions they wish and/or need to take and to assist them in achieving those objectives.

(b) Medical Center Based Call Center. A centralized program within the medical center with dedicated qualified staff supported by clinical decision support tools and operational policies and procedures whose primary goals are to improve overall health and maximize the use of health care resources. Appropriate levels of staffs support and educate veterans in accessing triage or health information services, in making decisions on the actions they wish and/or need to take and then assist veterans in achieving those objectives.

(c) Clinic Based Access to Clinical Calls. An integral clinic-based system operating during regular administrative and clinic hours that provides veterans access to their providers for clinical and health information questions and concerns.

(3) **Triage and Health Information Program.** A program, usually administered by a call center of a health care organization, designed to direct and educate those accessing triage or health information services on appropriate use of health care resources with the goal of improving overall health (see Utilization Review Accreditation Commission (URAC) Standards version 2.0).

(4) **Triage.** Classifying patients in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools (see URAC Standards version 2.0).

(5) **Telephone Triage.** The process of evaluating, advising, educating, referring and assuring safe, effective and appropriate disposition of client health problems by telephone (see Telephone Triage, Theory, Practice and Protocol Development by Sheila Q Wheeler).

(6) **Case Management.** A collaborative process which accesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes (see URAC Standards version 2.0).

(7) **Care Management.** A process which focuses services around the patient to ensure that the patient gets the right amount of care, in the right way, at the right time, and in the right place,

for the right cost. Care Management ensures the coordination of care across all settings, including the home, for all of one's diseases and episodes of illness, with a focus on optimizing a patient's health and functionality. Care Management integrates an assessment of living conditions, family dynamics, cultural background and other relevant personal or social circumstances into the veteran's treatment plan.

(8) **Self-management.** Self-management is the active process by which patients become involved in their own care, maintain health and avoid disease. Self-management requires information, confidence, skills (observation and/or monitoring, problem solving, decision-making, coping, securing the needed family and social support), and the ability to communicate and partner with health care providers.

(9) **Patient Education.** Patient education is any combination of information and education activities designed to assist veterans to access and appropriately utilize VHA health care resources across the continuum of care, become actively involved in health care decision-making; engage the needed family and social support systems; and achieve the desired self-management and coping skills.

(10) **24x7 Telephone Access to Clinical Care.** The provision of direct access to clinical staff that respond to questions from callers regarding clinical triage and health information, operational policies and procedures through a toll free or local number 24x7, 365 days per year (see URAC Standards version 2.0).

(11) **Enrolled.** This means a veteran has completed VA form 10-10EZ, Application for Medical Benefits, has had eligibility verified by VA, and has been assigned, by VA, into one of seven enrollment priority groups. Once enrolled, VA mails the veteran a letter to inform the veteran that the veteran has been enrolled into the VA health care system. Pursuant to enrollment regulations, Title 38 Code of Federal Regulations (CFR) 17.37, some veterans may receive certain care from VA without enrolling.

3. POLICY: It is VHA policy that by September 30, 2002, each Network will ensure that all of its enrolled patients are provided 24x7 direct telephone access to clinical staff who are trained to provide health care advice and information. ***NOTE:*** *The determination of how 24x7 access to all enrolled veterans will be provided is best made at the Veterans Integrated Services Network (VISN) level.*

4. ACTION

a. Each VISN must develop and implement a mechanism to ensure that all enrolled veterans have access via telephone to clinical care and services 24x7 by September 30, 2002.

b. All 24x7 telephone care programs must meet the following standards:

(1) Provide enrolled patients with a telephone number(s) that assures they have a telephone entry point 24x7. Different numbers may be provided to different patient groups and/or technology may be used to route calls to after hours call centers, etc.

(2) Provide clinical staff answering calls with direct timely access to the patient records by the end of December 31, 2003.

(3) Ensure that the minimum qualifications for call centers staff who answer clinical calls is a registered nurse who has completed an orientation and training program and who receives ongoing continuing education.

(4) Ensure Clinical Call Centers meet or exceed veteran expectations and comply with standards of practice for call centers pertaining to timeliness of access to clinical staff, required adherence to approved protocols, call escalation procedures, practice within the scope of licensure, etc., as described in URAC or other accreditation standards.

(5) Ensure primary care or other providers responsible for the patient and appropriate administrative staffs receive information that includes the algorithm and/or clinical protocol used, advice provided, and/or written progress note, by the next business day. Ensure that backup copies of these communications are kept at the call center or other location, as determined.

(6) Implement a mechanism to ensure that all clinical calls are documented and recorded in the patient record and elsewhere, as appropriate.

(7) Provide seamless and transparent linkages for patients between call centers and/or daytime call center programs. Implement a standardized mechanism to address or hand off calls to facility, regional call centers, Veterans Benefits Administration (VBA), etc., when required.

(8) Ensure that protocols are reviewed and approved by local and/or Network Clinical Staff Committee(s) and are reviewed annually and updated as necessary. This review will ensure that consistent advice is given to patients across the Network and in any place where clinical symptoms are addressed. The longer-term goal is to achieve consistency of protocols across VHA as best practice information is generated and disseminated.

(9) Appoint a physician medical or clinical Director for Network-wide call centers and, if desired, for local call centers.

(10) Ensure, in cases where the Network is providing symptom-related advice via other modes of access such as patient Web sites, that consistent information is provided and that consistent clinical advice and guidance are given across all modes of access. ***NOTE:*** *Facilities or Networks that provide advice via other modes of access must set and monitor standards for reading and responding to clinical-related electronic questions to ensure patient safety.*

(11) Implement a mechanism, in cases where self-management education, patient education, audio tapes etc, are provided as part of the call centers, to ensure that the information that is provided is consistent with what is provided in other places across the Network where patient education services and materials are provided. The longer-term goal is to achieve a level of consistency in the education materials and self-management advice provided veteran patients across VHA.

c. Ensure call centers apply for and subsequently receive accreditation by the American Accreditation Healthcare Commission-URAC or another appropriate accrediting body by the December 31, 2003. NOTE: This requirement is intended to be inclusive of facility-based day-time call centers to the extent applicable and appropriate to clinic-based calls. URAC standards have four criteria, containing thirty-one standards that are proprietary information, that address:

1. Confidentiality of patient and provider information,

2. Staff qualifications,

3. Program qualifications for triage, and

4. Health information upon which clinical activity is conducted.

NOTE: *URAC is currently the only accrediting body for telephone care and triage call centers.*

d. All call centers must collect information on the following measures and forward the results to VHA Headquarters on an annual basis. ***NOTE:*** *Details for reporting and specific definitions of terms for measures, etc., will be provided as a separate document.*

Measure	**Type of Measure**	**Published Private Sector Best Practices**	**Domain of Value**
Patient Satisfaction	Standard measure for clinical call centers	95 percent satisfied or very satisfied	Satisfaction
Adherence to Protocols	Standard measure for clinical call centers	> 90 percent	Safety and/or Quality
Patients' perceived need for Clinic and Emergency Department (ED) Visits (Measured by determining at the beginning of the call what the veteran believes they need to do and then asking what they plan to do at the end of the call.)	Standard measure for clinical call centers	40 to 50 percent	Cost and/or Quality
Telephone Care visit within 72 hours prior to emergent or urgent visit was appropriate according to the protocol.	Unclear if other organizations have measures that are similar.	None	Safety
Notification of Providers of Veteran Contact	Standard measure for clinical call centers	85 to 95 percent	Access and/or Quality
Documentation of all Calls	Typical measure for call centers	95 to 100 percent	Quality and/or Access
Call Center follow-up of clinical calls to determine status of patient and if advice taken	Typical measure for clinical call centers	Follow-up for 20 to 30 percent of clinical advice calls	Quality

e. Networks must develop a plan to incorporate the following measures into their telephone care and service program. ***NOTE:*** *In addition to the specific measures noted in the following, Network Directors need to consider additional information needed to develop a Telephone Care*

Program performance management and measurement system for all Telephone Care locations in the VISN.

Measure	Type of Measure	Published Private Sector Best Practices	Domain of Value
First Call Resolution (Calls not forwarded to another place for resolution)	Standard for call centers	85 to 97 percent	Quality
Abandoned Call Rate	Standard measure for all call centers	<2 percent	Access
Time in Queue	Standard measure for all call centers	<15 seconds	Access
Busy Rate	Standard measure for all call centers	< 1 percent	Access
Provider Satisfaction	Standard measure for clinical call centers	70 percent	Internal Customer Satisfaction
Triage to Higher Protocol Level (Escalation)	Typical measure for clinical call centers	10 to 15 percent	Quality
Patient and Internal Customer Complaints	Typical measure for call centers	< .001 percent	Satisfaction
Ratio of Unscheduled Visits and Visits to the ED, to Clinical calls to the Telephone Care Unit			Cost

e. Network directors are to consider the following when determining how telephone care and services will be integrated into their overall provision of care; i.e., consider:

(1) The role call centers might play in the implementation of the Emergency Room Services portion of the Millennium Health Care and Benefits Act in the avoidance of medically unnecessary Emergency Department visits and in receiving calls from Emergency Departments;

(2) How daytime approaches to the provision of health care advice and information might be incorporated into primary care; ***NOTE:*** *During regular business hours Networks are encouraged to provide veterans with the ability to talk to their primary care provider or team.*

(3) How, or if, self-management approaches and information should be incorporated into call centers' mission, policies and procedures;

(4) How telephone care and services can become an integral part of the care delivery system and provide support to the ongoing coordination of care, care management and/or patient follow-up;

(5) How telecommunication and computer telephony interfaces will be utilized to link call centers within and across Networks to facilitate ease of access for veterans and allow for load leveling, automatic call routing, automatic call forwarding to after hours call centers, etc.;

(6) In the implementation of Network Telephone Care Programs, Network directors are to consider the following in the development of policies and procedures:

(a) Staff selection, orientation and continuing education;

(b) Documentation of all calls; monitoring of calls (listening in);

(c) The role and use of non clinicians for administrative functions;

(d) The cost-effectiveness of call center operations;

(e) How callers who are not currently enrolled will be handled and/or be encouraged to enroll;

(f) How program will be marketed, communicated and rolled out across the Network; and

(g) How clinical call centers will be linked with other call centers such as other Network clinical call centers, VBA, the Enrollment Call Center, etc.

5. REFERENCES

a. Wheeler, Sheila Q, Telephone Triage, Theory, Practice & Protocol Development. Delmar Publishers Inc., Albany, NY, 1993.

b. American Accreditation Healthcare Commission, Utilization Review Accreditation Commission, (URAC) Standards, 1275 K Street, NW, Washington DC 20005, Phone (202)-216-9010.

c. VHA Program Guide 1120.1, Telephone Liaison Care, March 25, 1997.

6. FOLLOW-UP RESPONSIBILITY: The Chief Patient Care Services (11) is responsible for the contents of this Directive. ***NOTE:*** *Questions may be directed to the Office of Primary and Ambulatory Care 202-273-8558*

7. RECISSION: VHA Directive 10-94-022 is rescinded. This VHA Directive expires on October 31, 2005.

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